EXHIBIT D

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981106
EL PASO, TX 79998

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[redacted]	[redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted]	[redacted] M F X	[redacted]
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
[redacted]	Self X Spouse Child Other	[redacted]
CITY / STATE	8. PATIENT STATUS	CITY / STATE
[redacted]	Single Married Other X	[redacted]
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
[redacted]	[redacted]	[redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
[redacted]		[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X	a. INSURED'S DATE OF BIRTH / SEX
[redacted]		[redacted] M F X
b. OTHER INSURED'S DATE OF BIRTH / SEX	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
M F X		
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME
		AETNA USHC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
PROCURA		X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 04 08 2011

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. 722.10 LUMBAR DISC DISPLACE	3. 724.4 LUMBOSACRAL NEURITIS	23. PRIOR AUTHORIZATION NUMBER
2. 724.2 LUMBAGO	4. 724.02 SPINAL STENOSIS LUMB	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 08 11 04 08 11	21	02	63047	59	1234	56423 00	1		NPI	
2 04 08 11 04 08 11	21	02	63048	59	1234	11813 00	1		NPI	
3 04 08 11 04 08 11	21	02	63030	59	1234	30123 00	1		NPI	
4 04 08 11 04 08 11	21	02	22630		1234	38622 00	1		NPI	
5 04 08 11 04 08 11	21	02	22630	50	1234	38622 00	1		NPI	
6 04 08 11 04 08 11	21	02	22851		1234	11360 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
27-4820490 X	[redacted]	X YES NO	$ 257117 00	$ 0 00	$ 257117 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
JOHN CIFELLI, MD	ST MARY'S HOSPITAL 350 BOULEVARD PASSAIC, NJ 07055	(973 777 9279 NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07013
SIGNED 04 08 2011 DATE	a. [redacted] NUCC	a. [redacted] NUCC

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CIF000004

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981106
EL PASO, TX 79998

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	X
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	[redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	[redacted]
3. PATIENT'S BIRTH DATE / SEX	[redacted] / M / F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	[redacted]
5. PATIENT'S ADDRESS (No., Street)	[redacted]
6. PATIENT RELATIONSHIP TO INSURED	Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	[redacted]
CITY / STATE	[redacted]
8. PATIENT STATUS	Single / Married / Other X; Employed / Full-Time Student / Part-Time Student
ZIP CODE / TELEPHONE (Include Area Code)	[redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	[redacted]
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	[redacted]
a. EMPLOYMENT? (Current or Previous)	YES / NO X
b. INSURED'S DATE OF BIRTH / SEX	[redacted] / M / F X
b. OTHER INSURED'S DATE OF BIRTH / SEX	[redacted] / M / F X
b. AUTO ACCIDENT? / PLACE (State)	YES X / NO
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES / NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME	AETNA USHC
d. INSURANCE PLAN NAME OR PROGRAM NAME	PROCURA
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES X / NO — If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File. DATE 04 08 2011

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

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14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	
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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	
20. OUTSIDE LAB? YES / NO	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. 722 10 LUMBAR DISC DISPLACE; 2. 724 2 LUMBAGO; 3. 724 4 LUMBOSACRAL NEURITIS; 4. 724 02 SPINAL STENOSIS LUMB
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 08 11 04 08 11	21	02	22551		1234	11350 00	1		NPI	
2 04 08 11 04 08 11	21	02	22840		1234	18176 00	1		NPI	
3 04 08 11 04 08 11	21	02	20936		1234	1877 00	1		NPI	
4 04 08 11 04 08 11	21	02	20930		1234	1519 00	1		NPI	
5 04 08 11 04 08 11	21	02	62350		1234	4000 00	1		NPI	
6 04 08 11 04 08 11	21	02	77002	26	1234	413 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X / NO	28. TOTAL CHARGE $ 257117 00	29. AMOUNT PAID $ 0 00	30. BALANCE DU $ 257117
27-4620490	[redacted]				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JOHN CIFELLI, MD
SIGNED 04 08 2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST MARY'S HOSPITAL
350 BOULEVARD
PASSAIC, NJ 07055
a. [redacted]

33. BILLING PROVIDER INFO & PH # (973 777 9279)
NEUROLOGICAL SURGERY ASSOCIATES, PA
1054 CLIFTON AVENUE
CLIFTON NJ 07013
a. [redacted]

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CIF000005

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981106
EL PASO, TX 79998

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — 1a. INSURED'S I.D. NUMBER (For Program in Item 1)	[redacted] / X (ID)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	[redacted]
3. PATIENT'S BIRTH DATE / SEX	[redacted] / M
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	[redacted]
5. PATIENT'S ADDRESS (No., Street)	[redacted]
6. PATIENT RELATIONSHIP TO INSURED	Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	[redacted]
CITY / STATE	[redacted]
8. PATIENT STATUS	Single / Married / Other X; Employed / Full-Time Student / Part-Time Student
CITY / STATE	[redacted]
ZIP CODE / TELEPHONE (Include Area Code)	[redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	[redacted]
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	[redacted]
a. EMPLOYMENT? (Current or Previous)	YES / NO X
a. INSURED'S DATE OF BIRTH / SEX	[redacted] / M / F X
b. OTHER INSURED'S DATE OF BIRTH / SEX	M / F X
b. AUTO ACCIDENT? / PLACE (State)	YES X / NO
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES / NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME	AETNA USHC
d. INSURANCE PLAN NAME OR PROGRAM NAME	PROCURA
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	X YES / NO — If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.) I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature on File DATE: 04 08 2011

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: Signature on File

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES / NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 722 10 LUMBAR DISC DISPLACE
2. 724 2 LUMBAGO
3. 724 4 LUMBOSACRAL NEURITIS
4. 724 02 SPINAL STENOSIS LUMB
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 08 11	04 08 11	21	02	36220		1234	776 00	1		NPI	
2 04 08 11	04 08 11	21	02	20926		1234	2502 00	1		NPI	
3 04 08 11	04 08 11	21	02	22899	59	1234	2000 00	1		NPI	
4 04 08 11	04 08 11	21	02	22899	59	1234	2000 00	1		NPI	
5 04 08 11	04 08 11	21	02	22612		1234	36622 00	1		NPI	
6 04 08 11	04 08 11	21	02	20937		1234	2502 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID / 30. BALANCE DU
27-4620480 / X	[redacted]	X YES / NO	$ 267117 00	$ 0 00 / $ 267117 X

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
JOHN CIFELLI, MD
SIGNED: 04 08 2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST MARY'S HOSPITAL
350 BOULEVARD
PASSAIC, NJ 07055
a. [redacted]

33. BILLING PROVIDER INFO & PH #
(973 777 9279)
NEUROLOGICAL SURGERY ASSOCIATES, PA
1054 CLIFTON AVENUE
CLIFTON NJ 07013
a. [redacted]

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CIF000006

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981106
EL PASO, TX 79998

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [redacted]

3. PATIENT'S BIRTH DATE [redacted] SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

5. PATIENT'S ADDRESS (No., Street) [redacted]

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street) [redacted]

CITY [redacted] STATE [redacted]

8. PATIENT STATUS Single [ ] Married [ ] Other [X] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY [redacted] STATE [redacted]

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [redacted]

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER [redacted]

a. OTHER INSURED'S POLICY OR GROUP NUMBER [redacted]

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH [redacted] SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH [redacted] SEX M [ ] F [X]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME AETNA USHC

d. INSURANCE PLAN NAME OR PROGRAM NAME PROCURA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 04 08 2011

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 722.10 LUMBAR DISC DISPLACE
2. 724.2 LUMBAGO
3. 724.4 LUMBOSACRAL NEURITIS
4. 724.02 SPINAL STENOSIS LUMB

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 08 11	04 08 11	21	02	38230		1234	4406 00	1		NPI	
2 [redacted]										NPI	
3 [redacted]										NPI	
4 [redacted]										NPI	
5 [redacted]										NPI	
6 [redacted]										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X] 27-4620490

26. PATIENT'S ACCOUNT NO. [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 257117 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 257117 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

JOHN CIFELLI, MD

SIGNED 04 08 2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ST MARYS HOSPITAL
350 BOULEVARD
PASSAIC, NJ 07055

a. 1699748 NPI

33. BILLING PROVIDER INFO & PH # (973 777 9278)

NEUROLOGICAL SURGERY ASSOCIATES, PA
1054 CLIFTON AVENUE
CLIFTON NJ 07013

a. 12967 [redacted]

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981106
EL PASO, TX 79998

PICA

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
						X

1a. INSURED'S I.D. NUMBER: [redacted]

2. PATIENT'S NAME: [redacted]

3. PATIENT'S BIRTH DATE: [redacted] SEX: M F X

4. INSURED'S NAME: [redacted]

5. PATIENT'S ADDRESS: [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS: [redacted]

CITY: [redacted] STATE: [redacted]

8. PATIENT STATUS: Single Married Other X

ZIP CODE: [redacted] TELEPHONE: [redacted]

Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME: [redacted]

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: [redacted]

a. OTHER INSURED'S POLICY OR GROUP NUMBER: [redacted]

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH: [redacted] SEX: M F X

b. OTHER INSURED'S DATE OF BIRTH: [redacted] SEX: M F X

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA USHC

d. INSURANCE PLAN NAME OR PROGRAM NAME: PROCURA

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? X YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

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16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to Item 24E by Line)

1. 722 10 LUMBAR DISC DISPLACE
2. 724 2 LUMBAGO
3. 724 4 LUMBOSACRAL NEURITIS
4. 724 02 SPINAL STENOSIS LUMB

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 08 11	04 08 11	21	02	63047	59 AS	1234	36423 00	1		NPI	
2 04 08 11	04 08 11	21	02	63048	59 AS	1234	11613 00	1		NPI	
3 04 08 11	04 08 11	21	02	63030	59 AS	1234	30123 00	1		NPI	
4 04 08 11	04 08 11	21	02	22630	AS	1234	38822 00	1		NPI	
5 04 08 11	04 08 11	21	02	22630	50 AS	1234	38822 00	1		NPI	
6 04 08 11	04 08 11	21	02	22851	AS	1234	11660 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER: 27-4620490 SSN EIN X

26. PATIENT'S ACCOUNT NO.: [redacted]

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 250030 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DU: $ 250030

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SARAH BODIE, PA-C

SIGNED DATE 04 08 2011

32. SERVICE FACILITY LOCATION INFORMATION

ST MARY'S HOSPITAL
350 BOULEVARD
PASSAIC, NJ 07055

a. [redacted] b.

33. BILLING PROVIDER INFO & PH # (973 777 9279)

NEUROLOGICAL SURGERY ASSOCIATES, PA
1054 CLIFTON AVENUE
CLIFTON NJ 07013

a. [redacted] b.

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CIF000008

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981106
EL PASO, TX 79998

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
[redacted]	[redacted]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
[redacted]	01 08 1968 M F X	[redacted]
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
[redacted]	Self X Spouse Child Other	[redacted]
CITY / STATE	8. PATIENT STATUS	CITY / STATE
[redacted]	Single Married Other X	[redacted]
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (Include Area Code)
[redacted]		[redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
[redacted]		[redacted]
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X	a. INSURED'S DATE OF BIRTH / SEX
[redacted]		[redacted] M F X
b. OTHER INSURED'S DATE OF BIRTH / SEX	b. AUTO ACCIDENT? YES X NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
[redacted] M F X		
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME
		AETNA USHC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
PROCURA		X YES NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 04 08 2011

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
		FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
		FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. 722 10 LUMBAR DISC DISPLACE	3. 724 4 LUMBOSACRAL NEURITIS	
2. 724 2 LUMBAGO	4. 724 02 SPINAL STENOSIS LUMB	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04 08 11	04 08 11	21	02	22851	AS	1234	11360 00	1		NPI	
2 04 08 11	04 08 11	21	02	22840	AS	1234	18175 00	1		NPI	
3 04 08 11	04 08 11	21	02	69990	AS	1234	4000 00	1		NPI	
4 04 08 11	04 08 11	21	02	22899	59 AS	1234	2000 00	1		NPI	
5 04 08 11	04 08 11	21	02	22899	59 AS	1234	2000 00	1		NPI	
6 04 08 11	04 08 11	21	02	22612	AS	1234	38622 00	1		NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
27-4820490 X	[redacted]	X YES NO	$ 250090 00	$ 0 00	$ 250090 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SARAH BODIE, PA-C	ST MARYS HOSPITAL 350 BOULEVARD PASSAIC, NJ 07055	(973 777 9279) NEUROLOGICAL SURGERY ASSOCIATES, PA 1054 CLIFTON AVENUE CLIFTON NJ 07013
SIGNED 04 08 2011 DATE	a. NPI [redacted]	a. NPI 1396076848

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CIF000009

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AETNA USHC
PO BOX 981106
EL PASO, TX 79998

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)	
						X			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
				M F X					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
			Self X Spouse Child Other						
CITY		STATE	8. PATIENT STATUS				CITY		STATE
			Single Married Other X						
ZIP CODE	TELEPHONE (Include Area Code)		Employed Full-Time Student Part-Time Student				ZIP CODE	TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) YES NO X				a. INSURED'S DATE OF BIRTH SEX M F X		
b. OTHER INSURED'S DATE OF BIRTH SEX M F X			b. AUTO ACCIDENT? YES X NO PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME		
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? YES NO X				c. INSURANCE PLAN NAME OR PROGRAM NAME AETNA USHC		
d. INSURANCE PLAN NAME OR PROGRAM NAME PROCURA			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 04 08 2011

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14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
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1. 722 10 LUMBAR DISC DISPLACE
2. 724 2 LUMBAGO
3. 724 4 LUMBOSACRAL NEURITIS
4. 724 02 SPINAL STENOSIS LUMB

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04 08 11	04 08 11	21	02	20937	AS	1234	2502 00	1		NPI	
2	04 08 11	04 08 11	21	02	99230	AS	1234	4908 00	1		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE $ 250030 00	29. AMOUNT PAID $ 0 00	30. BALANCE D $ 250030
27-4620490					

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SARAH BODIE, PA-C
SIGNED 04 08 2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ST MARY'S HOSPITAL
350 BOULEVARD
PASSAIC, NJ 07055
a. 1699743888 NPI

33. BILLING PROVIDER INFO & PH #
(973 777 9279)
NEUROLOGICAL SURGERY ASSOCIATES, PA
1054 CLIFTON AVENUE
CLIFTON NJ 07013
a. 1396075548 NPI

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